California Medicine

Results of Psychotherapy

NORMAN Q. BRILL, M.D., *Los Angeles*

■ *A controlled double blind study was made of 299 non-psychotic female psychiatric clinic patients divided into six groups, with members of each group dealt with in a different manner from those in other groups. Those in one group had one or two hour-long psychotherapy sessions a week. Four groups were limited to brief visits but were given one of three kinds of drugs or a placebo. One group was merely put on a waiting list and received no therapy. As determined by a variety of independent measures, there was a fairly uniform average improvement of all groups except the one that received no treatment. Follow-up 10 to 18 months after termination of treatment revealed that the average patient had maintained her improvement and that those who had received no treatment showed considerable improvement after they were removed from the waiting list.*

The findings suggested that the widespread preference for the traditional outpatient psychotherapy is based as much on the physician's bias as on proven greater effectiveness over briefer treatment methods. There was some confirmation that many things other than the development of understanding enter into much of the so-called psychoanalytically oriented psychotherapy and may have profound effect on the outcome.

PSYCHIATRISTS WHO DO a considerable amount of psychotherapy prefer to think that they are being "scientific" in what they do, especially when using psychoanalytically oriented techniques. They believe this because these techniques are based on a comprehensive theory of personality development which lends itself to predicting behavior; and because the techniques are designed to help a person to understand the forces and unconscious origins of his emotional difficulties and thus help him change his way of reacting by giving proper value to rational considerations. There is a tendency for such psychiatrists to place a great reliance on what they do whether it is interpreting, clarifying, helping a patient to abreact or to understand his conflicts and fears; and there is a tendency to assume that the results of their treatment are primarily a function of these elements in their techniques.

However, it cannot be denied that the roots of psychotherapy are in the ancient practices of priests and witch doctors and its effectiveness seems to rest in part on the power of suggestion and on the ability of a person accorded special

Professor and Chairman, Department of Psychiatry, and Medical Director, The Neuropsychiatric Institute, University of California School of Medicine, The Center for the Health Sciences, Los Angeles.

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power or status to influence others who wish to be influenced.

Submitting oneself to another's influence and the underlying need for this in a person are looked down upon in our culture as manifestations of weakness, or inadequacy, and to some extent result in critical or belittling remarks being directed to the patient, to the psychiatrist-doctor and to the procedure. This belittling and skeptical attitude toward psychotherapy also tends to be extended to or displaced upon the results of such treatment and leads to remarks like "no one is really helped," despite the fact that there are many reported studies and testimonials to its effectiveness.

Variables in Psychotherapy

Reported studies, however, are often not comparable because of differences in techniques that were used. In attempting to define the nature of the modern psychotherapeutic process, an investigator is confronted by an almost limitless number of variables which enter into the interaction between therapist and patient and by a lack of yardsticks to measure these variables. From experiments in which therapists have been observed while treating patients (and especially private patients) it seems that what they *report* they do differs a good deal from what they *do* do. Greater significance is usually attached to remarks and silences, interpretations and encouragement, than to the fact that this patient was selected for treatment rather than some other patient; that a great effort is made to avoid any interruption of a session except in an emergency; that all attention is focused on the patient with a sympathetic understanding manner that is real or studied.

Young male psychiatrists, if given the choice, tend to select women rather than men, younger ones rather than older ones, and attractive ones rather than unattractive ones. They tend to choose patients who somehow convey an impression of readiness to receive help (or be influenced) and to accept for treatment patients with mild disability rather than those with severe disability. In general, they prefer patients they like and their reluctance to be observed while treating a patient is often greater than that which is seen in the patient. The reluctance at times approaches that which would be expected in situations involving some very highly personal activity.

Problems in Evaluating Results

Not only do different studies employ different measures of results, but even when measures are the same they may not be reliable. One cannot rely on just change in symptoms, since treatment may relieve a patient of a phobia but disrupt his marriage, or be complicated later by the development of a peptic ulcer. Or, a patient may overcome sexual frigidity but develop severe hypertension in its place.

How can understanding be measured? How can change in attitudes be accurately defined when it may take years merely to learn of their existence? What is a reliable measure of disability that can be used for the artist as well as for the bookkeeper, and how may interpersonal relationships which can vary from week to week and year to year be quantified? Does one consider immediate effects or only those which persist?

It is literally impossible to control for all variables without using some fantastically large sample that would permit the isolation of identical groups of patients who were matched not only for diagnosis, age, sex, education, intelligence, duration and severity of illness, symptoms, previous treatment and physical condition, but also for the more subtle but equally critical characteristics of motivation, personality, psychological mindedness, ego strength, expectation of help, current life situation, individual defenses and psychopathology.

Results of a Controlled Comparative Study

Despite all of these difficulties, we did not undertake a study of outpatient treatment.* In view of all the glowing reports on the use of tranquilizers, we wondered if a more economical treatment than the psychoanalytically oriented psychotherapy being used in our clinic was truly available. While our study employed criteria of change that are not totally comparable with criteria used in other studies, it permitted the comparison of different methods of treatment on groups of patients that were reasonably comparable.

From 1958 to 1963 we carried out a controlled study, double blind so far as drug therapy was concerned, on 299 non-psychotic female outpatients who, if there had been no limitation of staff, would in all likelihood have been treated

*The study is described in detail in The Archives of General Psychiatry Vol. 10, pp. 581-595, June; 1964. There will be no repetition here of the criteria used in the selection of patients, or of the details of the methods used in the study. It was supported by USPHS Grant No. MY-2923 from the National Institute of Mental Health.

with psychotherapy that involved an hour visit once or twice a week for many months. Instead, they were assigned at random to one of six groups. The patients in one group received psychotherapy of the kind the vast majority of clinic patients were getting. Those in three of the groups were limited to visits of 10 to 15 minutes a week and one of the three groups received meprobamate, another prochlorperazine and the third phenobarbital. Another group was also limited to the short visits but received an inactive placebo instead of one of the drugs. The last group was placed and maintained on a waiting list without treatment.

Following a treatment period or waiting period of from two to 12 months, each patient was re-evaluated clinically by several different persons and by means of a battery of psychological tests. In addition, the patient and her husband or close relative independently reported the results of treatment. The psychotherapy group was in active treatment for an average of five months. The average length of treatment for the patients treated with drugs was four months; they, of course, were seen less frequently and their sessions were limited to 10 to 15 minutes.

The characteristics of the patients assigned to the six groups were determined by several tests and when the groups were compared on the basis of these measures, no statistically significant differences were found.

Dropouts occurred in all groups. The proportion varied from 36 per cent in the meprobamate group to 50 in the prochlorperazine group, but no statistically significant differences were found among the six groups (Table 1).

The initial psychological test scores of those who completed treatment were found to be comparable to those of the dropouts. The small differences which were present were insufficient to introduce any important bias into the interpretation of results.

There was no particular diagnostic category which was significantly over-represented in the dropout group, although variations did occur.

The outstanding finding was the fairly uniform average improvement of all groups except the waiting list. This was seen in the estimate of change in patients' symptoms made by the physician and in Minnesota Multiphasic Personality Inventory (MMPI) profiles at the termination of treatment.

On a 16-item evaluation form filled out by the physician, no statistically significant differences among the treatment groups were seen (Chart 1). The psychotherapy group was rated slightly better on "ability to work effectively" and on "understanding of self." The latter rating probably to some extent reflected the prejudice of the physician regarding psychotherapy.

The patients, too, rated the change in their conditions. On almost all items those who received meprobamate reported more improvement than those who were treated with psychotherapy or other drugs (Chart 2). The difference has statis-

TABLE 1. — *Distribution of "Dropouts" by Treatment Group*

Treatment Group	*Number Assigned*	*Number Retested*	*Number Dropped Out*	*Per Cent Dropped Out*
Meprobamate	53	34	19	36
Placebo	55	30	25	45
Phenobarbital	53	28	25	47
Prochlorperazine	54	27	27	50
Psychotherapy	50	30	20	40
Waiting List	34	20	14	41
Total	299	169	130	43.5

X=2.85, df=5. Differences in percentages are not statistically significant.

TABLE 2.—*Patient's Response at Termination to the Question: "Do You Feel That You Have Been Helped by Treatment? (in General)"*

	Treatment Group					
	Psychotherapy	*Meprobamate*	*Placebo*	*Phenobarbital*	*Prochlorperazine*	*Total*
Helped very much	19	20	11	10	7	67
Helped somewhat	6	8	16	11	17	58
No change	1	2	3	5	3	14
Worse than before treatment	1			2	1	4
(No information)	23	23	25	25	26	122
Total	50	53	55	53	54	265

CHART 1.—RATINGS BY RESIDENT AT TERMINATION

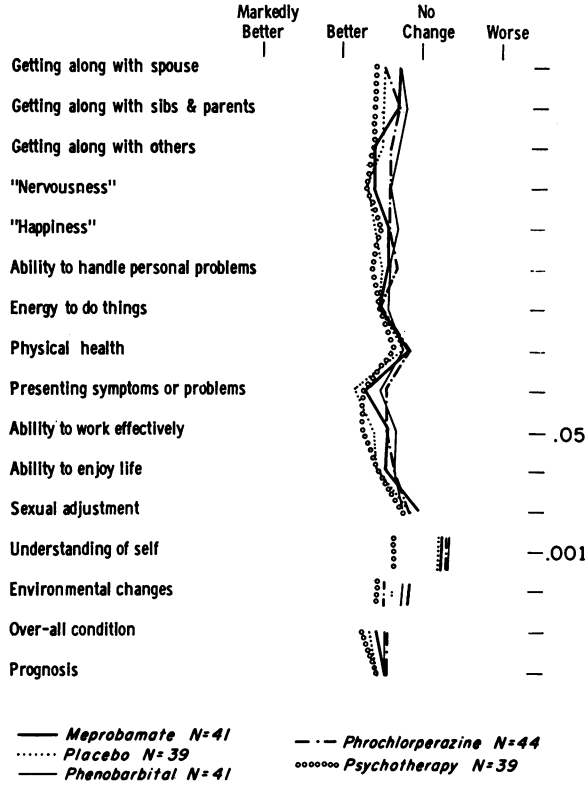
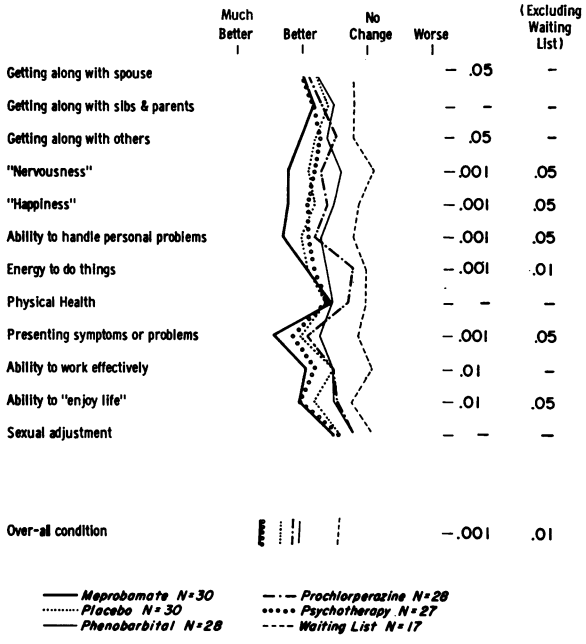


CHART 2.—RATINGS BY PATIENT AT TERMINATION



tical significance when this group is compared with the waiting list group that received no treatment. The rating of "overall condition" summarizes the results; here the meprobamate and psychotherapy groups are rated significantly more improved than the others. The patients' rating of effect of treatment is given in Table 2. It is of interest that they tended to consider themselves more improved than did their physicians. Relatives, too, tended to rate patients as more improved than did the physicians, and the ratings of relatives paralleled the meprobamate patients' more favorable reports. The psychotherapy group occupies an intermediate position.

Similar independent ratings were made by a social worker who compared social work evaluations that were made before and after treatment. The social worker making the rating had not seen any of the patients, but only the written reports. Her findings were consistent with the others.

We determined the attitude of the physicians toward psychotherapy and drug treatment. No correlation between attitude and treatment outcome was found. This was an unexpected finding, and it may be that our measuring instrument was not sufficiently sensitive.

Follow-up 10 to 18 months after termination of treatment revealed that the average patient had maintained her improvement. In fact, the average scores on almost all measures indicated some additional improvement. The waiting-list group showed the greatest average improvement during the follow-up period although it was still the lowest group. The differences between it and the treatment groups were much smaller than before and statistically not significant. There were now no differences among the drug and placebo groups, except perhaps for a tendency of the prochlorperazine-treated group to remain lowest. Psychotherapy patients fairly consistently had a slight (but statistically insignificant) edge over other treatment groups; this difference was overshadowed by the unexpectedly good results in most patients, regardless of treatment they had received.

Conclusions

The effect or lack of effect of the drugs used cannot be attributed solely to the drugs, since all patients who received drugs also received some sort of psychotherapy—generally as much as the physician was able to squeeze into the 10 or 15 minutes he was with the patient. In addition, the

mere prescribing of a drug without any planned psychotherapeutic interaction has meaning for the patient which will vary with the attitude and manner of the physician prescribing the drug and the nature of his relationship to the patient.

The results showed that many of the clinic patients studied did as well with relatively brief treatment interviews (10 to 15 minutes) supplemented by the judicious use of mild or innocuous medication, as they did with weekly psychotherapy sessions of one hour each over a long period. These findings were unexpected. They suggest that the widespread preference for the traditional outpatient psychotherapy is based as much on the physician's bias as on its proven greater effectiveness. There is some confirmation of the assumption that many things other than the development of understanding enter into much of the psychoanalytic psychotherapy that is practiced, and may have profound effects on the outcome. There is perhaps much more suggestion, more transference, more identification and more direct gratification of patients' need than we like to believe is the case.

However, as we have pointed out elsewhere, the study was not designed to detect the kind of subtle changes in attitudes which might uniquely occur with long-term, intensive psychotherapy, nor was it intended to define the really long-term results of treatment. Psychiatric residents, not experienced senior staff members, administered all treatment.

The findings do not justify any departure from the principle of providing treatment which is based on an understanding of psychodynamics and unconscious factors in emotional illness. Nor did the results of the study warrant discontinuing the use of intensive psychotherapy or psychoanalysis for types of disorders for which these are shown to be particularly indicated. Psychotherapy should be regarded as many things rather than just one thing. It is a procedure which should not be recommended without qualification, nor undertaken without clear definition of goals. Much research remains to be done to establish the indications for the various types of psychotherapy and to measure the long-term effectiveness.

Department of Psychiatry, U.C.L.A. School of Medicine, Los Angeles, California 90024.